Pt. Name________________________

MRN: __________________________

Patient Consent to Disclose Protected Health Information (PHI) and Billing Information to a Designated Representative

____ Patient Name (*Please print*)

_______________________ MRN

____ Address

_______________________ DOB

_______________________ City

__________________ State

________________________ Zip

I hereby give consent to provider _____________ (*name of provider*) to release protected health information (PHI) as indicated below to the following representative(s), outside requestor(s), and/or other provider(s).

Place check the information for requested disclosure:
_____Medical Information ONLY _____Billing Information ONLY _____Both medical and billing information
_____Other (Specify):____

Designated Representative Name	Relationship to Patient	Phone number	Emergency Contact
_________________________________	_______________	______________	Yes No (circle one)
_________________________________	_______________	______________	Yes No (circle one)
_________________________________	_______________	______________	Yes No (circle one)
_________________________________	_______________	______________	Yes No (circle one)

I understand:

- **This consent will expire in 24 months from the date of signature, unless I cancel it before that time. I can cancel this consent at any time by sending a written request to: Health Information Services, PO Box 62106, Santa Barbara, CA 93160.**
- **If I cancel the consent, it will NOT apply to information previously released with this consent. Once information is shared, this provider cannot prevent the person or organization that has access to it from sharing that information with others, and this information may not be protected by federal privacy regulations.**
- **I understand that I am not required to sign this consent and that this provider and its affiliates cannot base treatment or payment decisions based on my decision to sign this consent form.**

Signature: ____

Printed Name: ____ Date Signed ____________________

Relationship to Patient: ____

Reviewed by: ______________________________ ______________________________________
Staff Name (Please print) Department